

Euthanasia:

IMPOSED DEATH



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Dear Friend in Life:

Absolutes, as with truths, are not easily discerned today. Unfortunately we are living in an era and culture where Common Law and the long-held mores that have guided life, and the sanctity thereof, in the United States, and other Western nations, are being constantly threatened.

Thus, Human Life Alliance is blessed to have assembled a talented team of writers and reasearchers who through their works featured in this publication may shine light and truthful insight into what has become a very dark and misguided societal acceptance of euthanasia and assisted suicide!

On behalf of the Board of Directors, we wish to thank Julie Grimstad for her dedication and perseverance to this project, as well as each of the medical and legal professionals who courageously contribute their soul-filled intellect in defending the right to life of those most vulnerable, the voiceless! Foremost, we thank our legion of friends whose faithful support enables our mission of life to continue.


Paul J. Quinn
President


Jo Tolck
Executive Director

Euthanasia literally translated from the Greek means "good death." Some who promote euthanasia call it "mercy killing."



Death by euthanasia is neither good nor merciful. Therefore, in this supplement, the more accurate term "imposed death" is frequently substituted for "euthanasia."

Imposed death on the unborn is abortion. Imposed death on a newborn baby is infanticide. Imposed death on a child or an adult is known as euthanasia or assisted suicide.

Euthanasia, assisted suicide and other end-of-life issues are hot topics. Hardly a television news program, talk show, newspaper or magazine has not addressed end-of-life issues recently. Most Americans don't have the time or inclination to research what's behind the headlines, sound bites and slogans.

You may ask, "Why must I be more informed and concerned?"

Because the whole human race has a stake in the answer to the question, "Should imposed death be permitted and regulated by law?" History teaches us that a society which does not respect and protect all human life bears the seeds of its own destruction.

Allowing the termination of the lives of certain ones among us — the sick, the suffering, the disabled, the very elderly

— has profound repercussions for all of us.

This supplement examines the history of imposed death (assisted suicide and euthanasia), the facts about it and the experiences and opinions of those most intimately affected by it. YOU need the unvarnished truth in order to make informed decisions about matters of such vital importance.

ACKNOWLEDGMENTS

Many people have contributed their expertise, talents, and time to developing this supplement. We are grateful to all of them, but especially to Mary Senander, co-author/co-compiler of the first *Euthanasia: Imposed Death* supplement in 1997 as well as several subsequent revisions and updates. Finally, most deserving of mention and appreciation is my husband Bill for his patience and household help during the countless hours spent developing this new edition.

This supplement is dedicated to our good friend and mentor, Dr. Joseph R. Stanton, of happy memory, whose life's work was a testimony to the sanctity of human life.


Julie Grimstad
Writer and Editor

Julie Grimstad is the executive director of Life is Worth Living, whose members are dedicated to the authentic restoration of respect for human life. Julie co-founded and served as the director of the Center for the Rights of the Terminally Ill from 1985 to 2003. A patient advocate, public speaker and writer, she is recognized for her long-standing focus on end of life issues. She resides in Stevens Point, WI. Julie may be contacted by e-mail at lifeisworthliving@sbcglobal.net.

Isn't It MY Right to Decide?

Advocates of euthanasia and assisted suicide have captured words like "choice," "rights," "privacy" and "self-determination." Their intent is for individuals to have the "right" to choose how, when, where and why to die, and to receive assistance in dying from others.

The notion of *absolute autonomy*, that is, the unfettered right to decide all things for oneself, is a radical departure from the traditional moral order. The "right" to kill oneself has been denied in Western culture for good reason. Suicide is unnatural; it contradicts the natural inclination to self-preservation.

Suicide and attempted suicide have been decriminalized in every state because (a) prosecution was difficult and (b) society recognized that suicide/attempted suicide is a sign of grave psychological disturbance or instability. Just because suicide is legal does not mean it is a "right" — or a right "choice."

Suicide is an evil that benefits no one.

"It's always darkest just before the dawn." Many who have been saved

from suicide have attested to the truth of this adage. If they had succeeded in ending their lives in despair, they never would have seen the sun rise on some of their best days. Also, much has been written about the anguish and guilt which scar relatives and friends of those who commit suicide. Claiming one's so-called "right" to die by suicide or demanding assistance with death is a public act, not a private one. At the very least, a "right" to die requires the cooperation and tolerance (if not the consent) of others.

Although the expression "right to die" is seductive, it is fundamentally anti-libertarian. Giving the State the right to authorize our "right to die" begins the progression from voluntary imposed death to involuntary imposed death. Who will decide for those who cannot make their own choices? At what point do "rights" become expectations, even obligations?

Instead of pursuing a "right to die," let us strive to create an environment — a culture of life — in which no person feels compelled to seek the "quick fix" of death.

Must We Always Use Every Medical Treatment?

No. There may come a time when it is medically indicated and morally permissible to forgo a specific treatment, ventilator or surgery.

Insistence against the patient's wishes that every means available be used to postpone death is contrary to law, and would be senseless and inhumane. There is no moral or ethical requirement to provide or obtain treatment that is ineffective. Those treatments that are gravely burdensome or otherwise extraordinary are optional. However, people who want treatment should not be denied it.

We must be careful that what we judge to be a "burden" is NOT the patient's life, and that the particular treatment is truly a burden to the patient — not to the family, insurance

company or institution.

If a time comes when one can no longer heal or cure, we do not deliberately hasten death. But we do change our roles. We become CARE

givers, doing what we can to meet the physical, emotional, social and spiritual needs of the person.

We must maintain a clear distinction between allowing a person to die naturally, and omitting something with the deliberate intent to cause his or her death.

We must be careful that what we judge to be a "burden" is NOT the patient's life, and that the particular treatment is truly a burden to the patient — not to the family, insurance company, or institution.

For more information:

- *The Ramsey Colloquium, "Always to Care, Never to Kill," Statement by Jewish and Christian theologians, ethicists, philosophers, legal scholars, and others, 1992.*
- *John Paul II, Evangelium Vitae (The Gospel of Life), 1995.*

The Netherlands, Belgium and Switzerland are the only nations where active euthanasia and/or assisted suicide are legal. In the U.S., euthanasia advocates have been waging state-by-state battles seeking legal acceptance of assisted suicide. With the exception of Oregon, every attempt to legalize it has failed.

In 1988, the campaign to legalize "physician-aid-in-dying" in this country was launched in California with a proposal to allow doctors to directly kill patients by lethal injection. Euthanasia activists failed to collect enough signatures to get the measure on the ballot. Citizens, apparently, were uncomfortable with doctors as killers. Learning from this "dress rehearsal," euthanasia activists next proposed "physician-assisted suicide" (PAS) — a doctor would write the prescription for the lethal dose which the patient would self-administer. PAS was sold to Oregonians as necessary for terminally ill patients in severe, uncontrollable pain. This is what Oregon voters thought they were approving in 1994. But what did they actually get?

Oregon

After several legal challenges, Oregon's law became operative in November of 1997. By the end of 2003, the total number of prescriptions written for PAS was 193; reported deaths stood at 171. The major reasons patients chose assisted suicide were concerns about losing autonomy, decreasing ability to participate in activities that make life enjoyable, and loss of dignity.¹ Pain was not reported to be a significant factor.

A major infraction of the law is that non-terminally ill patients have received prescriptions for lethal drugs. Only patients with a life-expectancy of six months or less are legally eligible. The 2002 Oregon report showed that two patients who received prescriptions for PAS in 2001 were still alive at the end of 2002, more than a year later. The most recent report documents that one of the two patients died in 2003. The other patient was still alive at the end of 2003, more than two years after receiving the lethal drug prescription.²

There have been several unofficial reports of situations in which the lethal drug did not kill the patient. In one case, a woman had convulsions, vomited, was disoriented and uncontrollable. Her son-in-law put a pillow on her head and sat on it until she smothered. The

investigating district attorney reported that this action was not criminal.³ In Holland, when self-administered drugs fail to kill a patient, a lethal injection is given to finish the job. Will this happen in Oregon?

The Netherlands

The Netherlands legalized both assisted suicide and euthanasia in April 2001. For two decades prior to legalization, doctors who killed their patients could avert prosecution by following govern-

2002. Persons 16 years old and older can now make an advance written statement containing a request for termination of life. Children 12 to 16 years old may request and receive euthanasia or assisted suicide with the agreement of a parent or guardian. A person may qualify for euthanasia or assisted suicide if the doctor "holds the conviction that the patient's suffering is lasting and unbearable." There is no requirement that the suffering be physical or that the patient be terminally ill.⁵

Definitions

Fair debate begins with clear, honest definitions. If the correct words are used — and used correctly — we may witness a growing understanding of and consensus against imposed death by euthanasia and assisted suicide.

Euthanasia - Euthanasia is a Greek word (eu = good; thanatos = death) and generally means an action or omission intended to cause death.

- Euthanasia can be an action (act of commission), i.e., lethal injection, shooting, smothering.
- Euthanasia can be an omission, such as intentionally causing death by withholding or withdrawing necessary and ordinary (usual and customary) care, medical treatment, or food and fluids.

There is no moral distinction between an act that is intended to cause death and an omission that is intended to cause death. The victim is equally as dead.

- Euthanasia can be voluntary - that is, the person gives consent to be killed.
- Euthanasia can be involuntary - that is, the person is incapable of giving consent or does not give consent.

Mercy Killing - Euthanasia is sometimes called mercy killing. The word "mercy" describes the (assumed) motive; "killing" describes the act.

Assisted Suicide - Suicide is the taking of one's own life. In assisted suicide, someone else provides an individual with the information, guidance, and means to take his or her own life.

Aid in Dying - Aid in Dying is a euphemism for assisted suicide and euthanasia.

ment-endorsed guidelines. The patient's request had to be voluntary, "termination" of the patient's life had to be a last resort for intolerable suffering, etc. In reality, the guidelines have been routinely ignored. Concerned about abuses, the Dutch government conducted studies in 1990, 1995 and 2001 in which physicians' anonymity and immunity were guaranteed. These studies revealed several thousand cases a year in which physicians "terminated the lives of patients without an explicit request." A quarter of physicians admitted having killed patients who had not given consent; another third could conceive of doing so.⁴

Holland's law took effect on April 1,

Belgium and Switzerland

In May 2002, Belgium passed a euthanasia law modeled after Holland's law.

In Switzerland, assisted suicide is not formally legal, but it is tolerated. A "right to die" organization, Dignitas, helps foreign patients commit suicide. The "suicide tourist" arrives in Zurich and has a visit with a Swiss doctor (provided by Dignitas) who supplies the lethal drugs if he judges the patient's decision "rational." The tourist is then escorted to a small apartment where the lethal drugs are prepared by a volunteer and two witnesses are present. After death, the local authorities are notified.⁶

Taking Matters into Their Own Hands

A number of "right to die" activists, here and abroad, have taken matters into their own hands. For example, Caring Friends is a program of the Hemlock Society (now calling itself "End of Life Choices") which has its national headquarters in Denver. Hemlock has been a mover and shaker behind every effort to legalize assisted suicide in the U.S. Apparently, legal "progress" is too slow to suit Hemlock and Friends. Caring Friends trains volunteers to assist suicides, while Hemlock provides how-to-commit-suicide information to "members" by mail. Caring "friends" use a plastic bag over the head and helium gas to assist suicides, which Hemlock touts as producing "gentle, quick and certain death."⁷

Conclusion

Opponents of medically-imposed death believe the right to life is inalienable (God-given, not state-given) and universal. It is against all that is rational to abet suicide and permit the killing of medically vulnerable citizens in one state or one country while protecting them in another. Legalizing medical murder does not change a crime into a medical treatment; rather, it turns the law itself into an accessory to murder.

For more information:

- *Physicians for Compassionate Care, P.O. Box 6042, Portland, OR 97228, (503) 533-8154.*
- *Marker, Rita L. and Smith, Wesley J., "Words, Words, Words," www.internationaltaskforce.org.*

¹ *Oregon Death With Dignity: 6th Year Report, Oregon Department of Human Services, 3/9/04.*

² *Stevens, Kenneth, MD, "Latest assisted suicide report should be a cause for alarm," The Oregonian, 3/12/04.*

³ *Wilke, J.C., MD, "Euthanasia - Where is it Today?" Life Issues Connector, 2/04.*

⁴ *Hendin, Herbert, M.D., "The Case Against Physician-Assisted Suicide: For the Right to End-of-Life Care," Psychiatric Times, 2/04, Vol. XXI, Issue 2.*

⁵ *"Holland's Euthanasia Law," www.internationaltaskforce.org.*

⁶ *"Death Tourism: One-way trip to Switzerland," International Task Force on Euthanasia and Assisted Suicide Update, 2002, Vol.16, No.3, p.1.*

⁷ *"Helium," Hemlock Timelines, No. 83, Spring 2000, p.12.*

by Rita L. Marker, J.D.

When her husband, who is her court-appointed guardian, first sought to end her life by removing her food and fluids, few people outside of her Florida neighborhood had heard of Terri Schiavo. But because her parents love her so much and have fought to protect her from death by dehydration, Terri's story has touched hearts across the country.

The *Chicago Tribune* said it well. In a cover story accompanied by a photo of Terri smiling at her mother, the headline said, "The Face that Moved a Nation."

As the ongoing struggle over Terri's life has unfolded, we have been deluged with calls from people asking if this could happen to them or to someone they love.

The answer is "yes."

You are at risk unless you have taken the simple but necessary step of signing an advance directive that will protect you if you are ever unable to make your own health care decisions. This is known as a durable power of attorney for health care.

It's **not** the same as another type of advance directive known as a "living will." (The living will — sometimes called a "directive" or a "declaration" — is downright dangerous. It actually gives power over your life and death to an unknown physician.)

In a durable power of attorney for health care, you designate a trusted family member or friend to make health care decisions for you if you are unable — either temporarily or permanently — to do so for yourself.

Most people think such a document is only for those who are very sick or very old. That's not true. **It's absolutely essential for anyone who is 18 years old or older.**

Some (but not all) states have laws to cover a patient who hasn't designated someone to make health care decisions. Such laws contain a "priority listing" of those who can make decisions for an incapacitated patient. But in some states, those decisions may be limited to withholding or withdrawing treatment. They may not give the necessary authority to protect a patient. In other states, the law gives doctors the power to decide for patients if there are conflicts among those on the list.

Here are just three illustrations of what can happen if you haven't specifically named someone to make your health

care decisions:

- **Bob is a 19-year-old college student.** He is seriously injured in a sports accident. His condition is now stabilized. He is expected to improve, but he is not able to communicate yet. Some decisions must be made about his therapy and treatment.

Bob's parents are unable to get information from his medical records and have no authority to make decisions for him because Bob is in a state that does not have a priority listing of decision makers.

- **Joe and Sally are married with three children:** 15-year-old Bob, 18-year-old Tom and 20-year-old Mary. Driving home from a local restaurant, Joe and Sally are hit head-on by another car. Joe is killed. Sally is in critical condition.

Sally's twin sister Sue, who is very close to Sally and with whom Sally had often discussed her wishes about health care, rushes to the hospital. She attempts to get information about Sally's condition. She is told the law prohibits disclosing such information to her. Instead, the information can be given to Tom and Mary who, under state law, have the authority to make medical decisions for their mother.

Unfortunately, Tom and Mary do not get along with each other and the law requires agreement between them before any action can be taken. This leads to a delay in authorizing treatment that could have vastly improved Sally's ability to recover fully.

- **Alex is a 57-year-old truck driver.** While mowing the lawn, he has a heart attack. Due to lack of oxygen, he has sustained brain damage. He hasn't named anyone to make health care decisions but he lives in a state with a priority listing that gives his wife Anna first priority in making his decisions. Anna knows that Alex would not want a ventilator but would want to be tube fed if necessary.

Alex is breathing on his own and is being fed by tube. His brother Dave objects to the tube feeding. The doctor in charge of Alex's care thinks the tube feeding should be stopped.

In the state where Alex and Anna live, the attending physician or an advanced practice nurse can select a

decision-maker who is ranked lower in priority if, in his or her judgment, that person is "better qualified." Because Dave agrees with him, the doctor decides Dave is better qualified than Anna to make decisions for Alex. The tube is removed and 12 days later Alex dies of dehydration.

To be certain that a person you trust will be making decisions for you if you can't do so yourself, you must have a durable power of attorney for health care that specifically names that person.

As with any legal document, the wording of the durable power of attorney for health care is critically important. And it must comply with the laws in your state.

The PMDD

That's why the International Task Force (ITF) formulated the Protective Medical Decisions Document (PMDD). The PMDD is a durable power of attorney for health care that has been drafted to protect you.

It gives the person you name to make your health care decisions the authority to act on your behalf. That person is generally referred to as your "agent."

The PMDD limits your agent's authority in one specific way. It clearly states that your agent does *not* have the authority to approve the **direct and intentional** ending of your life.

For example, your agent may not authorize that you be given a lethal injection or an intentional drug overdose. Further, your agent may not direct that you be denied food or fluids **for the purpose of causing your death** by starvation or dehydration.

This limitation not only protects you, but it protects your agent from being subjected to pressure to authorize such actions.

The PMDD also has specific directions that are necessary in the current medical climate.

For example, some health care providers have taken it upon themselves to put Do Not Resuscitate (DNR) orders in place without the patient's or agent's authorization. Similarly, some health care providers, ethics committees and health facilities are making decisions about what is "appropriate" or "beneficial" based on institutional cost-containment considerations, not on the basis of what is best for or wanted by the patient.

The PMDD makes it clear that DNR orders and decisions about what is

"appropriate" or "beneficial" are to be made only by your agent (if you're not able to do so).

There's something else.

Some states require that, when a durable power of attorney for health care is distributed in printed form, it must have a specifically printed "notice" or "warning." The ITF distributes state-specific PMDDs for those states as well as a Multi-State PMDD for use in other states.

A PMDD Protects You

When you have a PMDD, you or someone you've selected — not some unknown physician or nameless bureaucrat — will make your health care decisions.

Filling out a PMDD takes only a few minutes — far less time than applying for health insurance, car insurance or even applying for a credit card. And it can be even more important.

Having a PMDD can mean the difference between life and death.

Each PMDD packet contains: detailed questions and answers about the PMDD; a checklist to use when signing your PMDD; three PMDD forms (so you can provide documents with your original signature to your agent and to any alternate agents); and a wallet card on which you can write the names and phone numbers of your agent and alternate agents so they can be reached in case of an accident or emergency.

If you don't already have an advance directive, the PMDD packet is a must. If you have another type of advance directive, I urge you to review the PMDD and decide whether you wish to replace your existing document.

And, if you already have a PMDD, I encourage you to see to it that every member of your family and all of your friends have one as well.

While you may never be in a situation where a PMDD will be needed, isn't it a good idea to prepare for the worst while hoping for the best?

Isn't it better to be safe than sorry?

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by Wesley J. Smith, J.D.

Who should have the right to decide whether you receive life-sustaining medical treatment during a critical or terminal illness? Most would say with great confidence, "Me. Or, if I am unable to decide, then my family."



That should be true. Indeed, it used to be true. But in a growing number of hospitals, your right-to-decide is being taken away from you (or your family) by bioethicists and members of the medical intelligentsia who believe that their values and priorities should count more than yours when determining whether you shall receive wanted medical treatment. To put it bluntly: even if you want to live, even if you want medical treatment to enable you to fight for your life, you may be told that the hospital reserves the right to refuse service.

Welcome to the world of "futile-care theory," one of the hottest and most-dangerous topics in contemporary bioethics. While you may never have heard of it, stories about the spread of futile-care theory are rife throughout medical and bioethics literature, reported and argued about in such influential publications as *The Journal of the American Medical Association*, *The New England Journal of Medicine* and *The Hastings Center Report*.

Unfortunately, few people read these highbrow publications. Worse, despite being a bombshell story, this growing threat has mostly been ignored by the popular media.

This better change fast. As you read these words, quietly, slowly, inexorably, mostly behind the closed doors of hospital ethics committees, "futile care" or "inappropriate care" protocols are being put into place in hospitals throughout the country. The first time most patients and their families become aware that doctors are being given the right to say "no" to wanted medical treatment (other than comfort care) is during a medical crisis when they are at their most defenseless and vulnerable.

Hospitals in Des Moines, Iowa appear to be the latest institutions to stealthily

adopt futile-care policies. As reported by the January 2, 2003 *Cedar Falls Courier*, some area hospitals now have rules in place that permit "medical staff to withdraw treatment over a family's objection." True, when there is a dispute, families and patients have a right to a hearing in front of a hospital ethics committee. But that isn't much solace. Such committees could easily become more stacked decks than dispassionate decision makers, mostly comprised of well-meaning people who either are part of the institutional culture or who have been trained to believe that futile-care theory is the right thing to do.

According to the *Courier* report, if patients lose the right to receive treatment in the ethics committee, they have two choices. First, they can find another hospital. But this would be no easy task given that patients refused treatment are likely to be the most expen-

means that if you try to legally force a hospital to continue treatment, you would probably have to pay your lawyer by the hour. Lawyers often charge hundreds of dollars an hour, meaning that a fully litigated case, even without appeals, could cost literally tens, if not hundreds of thousands of dollars.

On the other hand, having very deep pockets, the hospital administration would not be concerned in the least about the cost of their lawyers. If fully unleashed, the hospital's corporate lawyers could file enough motions, take enough depositions and pursue every possible appeal, to the point that you, quite literally, could litigate yourself into bankruptcy.

Beyond the financial impracticalities of suing a hospital, one of the primary reasons for crafting futile-care proto-

policies being adopted by some hospitals in Houston, Philadelphia and Detroit, just to mention a few.

It used to be that people were afraid of being hooked up to machines when they wanted nothing more than to go home and die a peaceful, natural death. The early bioethics movement deserves great thanks for helping do away with that form of abuse by pointing out that patient autonomy means the right to say no to unwanted interventions.

But that was before the bioethics movement largely abandoned the sanctity of life ethic for an express or implicit utilitarianism that views the value of human life through a distorting prism of "quality." That was before most bioethicists came to believe that health-care rationing should be imposed.

Now, a new medical hegemony is arising, one that proclaims the right to declare which of us have lives worth living and therefore worth treating medically, and which of us do not. In essence, what is being created in front of our very eyes (if we would only see) is a duty to die. Unless people object strongly and legislatures take active steps to intervene, this new and deadly game of "Doctor Knows Best" will be coming soon to a hospital near you.

Reprinted with permission of the author. Source: *National Review*, January 6, 2003.

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From Small Beginnings...

"Whatever proportions these crimes [in Nazi Germany] finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitudes of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived."

Dr. Leo Alexander, Psychiatrist and Chief American Counsel at the Nuremberg Tribunal, "Medical Science Under Dictatorship," New England Journal of Medicine, July 4, 1949

sive to care for. With the coming of HMOs, and the Medicare Diagnosis Related Group (DRG) capitated payment system, hospitals now generally lose money on patients requiring intensive or extended care. Thus, getting another hospital to accept a patient that a current hospital doesn't want to treat anymore may be a near impossible task.

That leaves the courts and filing a lawsuit to force the hospital to sustain the patient's life. That could work, but it is no sure bet. There have been lawsuits filed in various parts of the country over refused treatment, but the results have gone both ways. Moreover, no definitive case has yet been litigated to the appeals court stage. Thus, there are no legal precedents governing the legality or permissible scope of these quickly spreading futile-care policies. But even though a lawsuit could be successful in theory, it might very well prove utterly impracticable to pursue. These are not the kind of cases that lawyers accept on a contingency basis. This

cols has been to improve the chance that the hospital would prevail in court. Indeed, an article in the Fall 2000 *Cambridge Quarterly of Health Care Ethics* explicitly advised hospital bioethicists to put these protocols in place as a way to prepare for the litigation bioethicists presume would be filed by people furious at having wanted medical treatment refused. As the authors of the *Cambridge Quarterly* article opined, "Hospitals are likely to find the legal system willing (and even eager) to defer to well-defined and procedurally scrupulous processes for internal resolution of futility disputes."

Nobody knows just how many hospitals have adopted these protocols or where they have been put in place. But if the professional literature is to be believed, futile-care theory is spreading quickly. The *Cambridge Quarterly* article cited above found that 24 out of 26 surveyed hospitals in California had such policies in place and that, of these only seven left the final decision to the patient or family. I have read about

"It's time for the U.S. to consider moving from birth control to 'death control'...Death control clearly has considerable potential as a reallocative mechanism for scarce resources such as health care."

- Barbara Logue, demographer¹

It is becoming increasingly apparent that, at least for some people, the desire to limit care and end the lives of elderly, disabled and seriously ill people is an economic issue. Rather than being honest about it, they hide their cost-cutting motive behind terms like "compassion" and "death with dignity." Wesley Smith, author of the book *Forced Exit* and featured on p. 5 of this publication, maintains that money is "perhaps ultimately the most influential and dangerous force driving the euthanasia juggernaut."

In 1977, Robert Derzon, head of the Health Care Financing Administration of the Department of Health, Education and Welfare, pointed out that the "cost-savings from a nationwide push toward 'Living Wills' is likely to be enormous." In 1987, Dr. Otis Bowen, Secretary of Health and Human Services, testified before the Senate Finance Committee that the only way to attack the problem of health care expenditures was to

encourage Americans to sign Living Wills. In due course, the federal Patient Self-Determination Act (tellingly attached to the 1990 budget reconciliation bill) became law. It requires health care facilities and programs that receive Medicare and Medicaid funds to give every adult patient the "opportunity" to sign a Living Will upon admission.

How will getting people to sign Living Wills save so much money? Refusal of "life sustaining procedures," via Living Wills, causes death. Dead people don't require health care.

HMO's are catching on to the "benefits" of killing people. They make money by cutting costs. Starving and dehydrating to death an otherwise non-dying disabled person takes about 10-14 days of "comfort care only" versus perhaps years of "life-sustaining" care and treatment. Assisted suicide costs about forty dollars per lethal dose of drugs versus \$40,000 or more to provide appropriate

medical care for a terminally ill patient. In Oregon, where assisted suicide is legal, a Kaiser Permanente Northwest (HMO) executive e-mailed a memo to more than 800 Kaiser physicians asking for volunteers to participate in the deadly practice.²

Oregon systematically rations medical treatment for people who need it most. The state's current fiscal crisis has caused thousands to lose prescription drug coverage and over 200 (out of about 800 listed) medical treatments are not covered for poor people who receive Medicaid benefits. But the Oregon Health Plan does cover lethal doses of drugs so they can kill themselves.

Potential savings, no doubt, are adding momentum to the "futile care" movement sweeping through our health care system [see p. 5]. In fact, no one knows how many "expensive to care for" patients' lives already have been cut short against their wishes (and possibly illegally) by denying them life-sustaining treatment.

Disturbing? Yes. And, it's just beginning. Texas and California already have

statutes that appear to authorize futile care decisions. Other states will surely follow.

Some professionals devise a sort of "pecking order" for determining who lives and who dies based on "quality of life" and the best use of "limited resources." This is profoundly unjust.

Our great nation was founded on the tenet that all human life is of equal value, that every one of us has an inalienable right to life. If we believe that, then we must do all within our power to protect those whose sense of safety and whose very lives are imperiled by cost-cutting strategies. Rather than accepting the "solution" of imposed death, why not work for practical cost-cutting measures such as eliminating fraud, error, and waste, and encouraging high-quality, lower cost care options?

Whatever the cost, the aim of medical treatment must be to heal, to alleviate suffering, and to care, but never to kill.

¹ "The Methuselah dilemma: Can America afford grandma and grandpa?" *Business (Mpls.) StarTribune*, 1/12/97:D1,4.

² Smith, Wesley J., "Doctors of Death," *National Review Online*, 8/19/02.

Would You Never Want to be "Hooked Up to a Machine?"

by Marlene Reid (President Emeritus, Human Life Alliance)

Your life or the life of a loved one may depend on having correct and clear information about a medical machine, the ventilator, commonly called a "respirator."

Respiration is a bodily function, not a machine's function. It can only occur when the body's respiratory and circulatory systems are intact and functioning. Respiration is the breathing in of oxygen taken from the air, the exchange of oxygen and carbon dioxide in the lungs and in living tissues throughout the body, and the exhaling of carbon dioxide into the air. A ventilator is an aid in breathing and can be a valuable aid in improving respiration. The ventilator machine supports the ventilation part of breathing, the moving of air, but it does not and cannot cause the other part of breathing — respiration. Thus, the machine should always be referred to by its accurate name, "ventilator."

Until recently, I had not given much thought to the indispensable role that a ventilator plays in the healing process. Three real-life dramas brought the truth home to me. Ventilators are commonly

and effectively used to save lives, as well as to prolong them.

My 41-year-old nephew was suffering from shocked-lung syndrome after being injured in an automobile accident. This is a condition in which the elasticity of the lungs is greatly curtailed, causing intense pain and severe shortness of breath. To give his body a chance to heal without fighting for breath, the doctors induced a comatose state and put him on a ventilator. He was on the ventilator for more than three weeks. His life was hanging by a thread or, more literally, a machine. When he was finally taken off the ventilator, his body took over, eventually completing the healing process. Today he is back working at his heavy duty construction job — thanks to the ventilator and endless prayers.

In the second drama, a dear friend sustained a head injury. Because his traumatized body started to shut down fol-

lowing surgery to close the wound, he too was put into a medically induced coma and hooked up to a ventilator. He was in critical condition. After five days, he was taken off the ventilator and his natural breathing functions took over. This friend, who at 80 doesn't believe in retirement, is back working fulltime, none the less for wear.

Imagine the outcome had he signed a Living Will which stated that he would **never** want to be put on a respirator (the term often used in Living Will documents). If you have

made a statement to this effect, either orally or in writing, you should promptly and emphatically rescind it.

In the third case, a friend had a cardiac arrest. He was taken to the hospital by ambulance and subsequently pronounced "brain dead." The attending physicians wanted to disconnect life support, but his wife wouldn't hear of it until all of their children could get home to say their goodbyes. After 72

hours, the sorrowing children had bid their father farewell. When life support was discontinued, their father sat up in bed and started talking to the family! He went home shortly thereafter and the family was able to enjoy his company for four more years before he was called home to his Maker. WHAT IF his wife had given consent to stopping life support before his body's own healing powers had a chance to take their course with the aid of a ventilator?

I am now an enthusiastic believer in the power of the ventilator. We must all do our part to dispel the mistaken assumption that use of the ventilator is an extraordinary or heroic measure used to temporarily prolong life. Its role in protecting and preserving lives must be made more widely known. Providing accurate information about medical technology's benefits gives people the ability to make truly informed treatment decisions.

For a copy of the brochure *LIFE SUPPORT: the ventilator*, contact American Life League at (540) 659-4171 or visit their website at www.all.org.

"Imagine the outcome had he signed a Living Will which stated that he would **never** want to be put on a respirator"

by Marlene Reid (President Emeritus, Human Life Alliance)

The scholarly and deeply disturbing book, *A Sign for Cain: An Explanation of Human Violence*, by



Fredric Wertham, MD, should be required reading for every high school and college student in this country. It documents the

small beginnings, the escalation and the ultimate scope of the euthanasia program which got its foothold in Germany prior to the Nazi regime and World War II. Dr. Wertham reveals how the book *The Release of the Destruction of Life Devoid of Value*, published in Leipzig in 1920, and authored by jurist Karl Binding and psychiatrist Alfred Hoche, influenced and crystallized the thinking of a whole generation. Binding and Hoche wrote: "By death with dignity, we don't mean only the right to death with dignity, but much more, the legally acknowledged right to the complete relief of an unbearable life . . ." They called the legalization of euthanasia a "simple duty of justified compassion."

Brutal seeds of bigotry and discrimination germinated for years. German school children studied graphs and calculated how many services, how much money, bread, jam and other necessities of life, could be saved by killing people

who were a "drain on society." German filmmakers and writers romanticized euthanasia as a "loving" choice. Most medical personnel, and eventually soldiers, blindly accepted and enacted the ideology put forth by Binding and Hoche. Ordinary citizens, concerned for their own welfare, ignored dangerous warning signs. Many churches failed to speak out. The Nazi-controlled media perpetuated lies and half-truths. In short, economic policies obscured human rights.

Wertham tells us that at least 275,000 psychiatric patients were killed — many of whom were merely aged and infirm. Psychiatrists would actually take aged people from their homes for a cursory psychological exam, send them to an institution and from there to the gas chambers.

Thousands of children were also murdered. According to an *ABC Nightline* segment that aired on June 6, 1997, the preserved brains from 417 children were discovered in a basement storage room of Spielgelgrund Hospital in Vienna. Dr. Heinrich Gross, who was in charge of the children's ward at Spielgelgrund and who personally signed 238 death certificates during this period, claims this as the "greatest collection of brain specimens." Yet, instead of being charged as a war criminal, Dr. Gross, at the time of the 1997 discovery, was "a respected physician living a quiet life outside of Vienna" and frequently called as an Expert

Witness on brain disorders.

Once the programs, personnel and protocol were in place, the horror of "The Holocaust" exploded. "Technical experience gained first with killing psychiatric patients," Wertham writes, "was

the crossroads of the corruption of medicine with the corruption of law. Corruption of law came first in this country with the U.S. Supreme Court abortion decision of 1973. The corruption of medicine followed. In

Germany, in the 1930's, the corruption of medicine came first. But the Holocaust could not have come

about with the corruption of medicine alone. It took the corruption of law to make euthanasia legal. There is no doubt that if the doctors in Germany had stood for the right to life of every individual, the Holocaust at the very least would have been slowed down and minimized."

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- Gallagher, H.G., *By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich*, Henry Holt & Co., 1990.
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* www.noapathy.org/tracts/crimeofbeingalive.htm

"Those who cannot remember the past are condemned to repeat it." - George Santayana

utilized later for the destruction of millions. The psychiatric murders came first."

It is not popular to compare what's happening in contemporary America with the German euthanasia program. Certainly there are differences. Yet, we make a great mistake if we fail to recognize similarities and learn from history. How can we not worry when U.S. society already:

- Condone the killing of 1.2 to 1.5 million unborn babies every year through abortion — then permits the harvesting of organs and tissue from their tiny bodies?
- Blithely accepts imposed death by starvation and dehydration of our own medically vulnerable citizens?
- Redefines death to permit the removal of vital organs from certain people who are NOT yet dead?

Are Americans who engage in and allow these practices any less barbaric than the Germans before and during World War II?

C. Everett Koop, MD, during his tenure as Surgeon General of the United States (1981-1989), warned, " . . . we are at

DOCTORS AS HEALERS, NOT KILLERS

Medicine's ancient charge is "Above all, do no harm." Legalized medically-imposed death would have a profound impact on the practice of medicine. Doctors would relinquish their time-honored role as healers (and, when they cannot heal, as comforters). Other professionals — nurses, social workers, administrators, pharmacists and chaplains — would be enlisted as accomplices.

Likely, few physicians would practice imposed death. However, as with the practice of abortion and with the euthanasia program in Nazi Germany, it takes but a few doctors to kill many people.

Recognizing that most imposed death proposals require the participation of

health professionals, more physicians, nurses and pharmacists are seeking conscience clause laws. Several nurses have lost their jobs for refusing to obey orders not to feed their patients. In the New Jersey case of Nancy Ellen Jobes, health care professionals took out newspaper ads begging for their patient's life.

The Hippocratic Oath

The Hippocratic Oath was written about 400 B.C. It distinguished Hippocratic physicians from their sorcerer and charlatan forebears by the rejection of killing:

"I will neither give a deadly drug to anyone if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortion

pessary. But I will preserve the purity of my life and my art."

For centuries, upon completion of their training, physicians pledged to that Oath. In modern times, Hippocratic principles were expressed in the 1948 World Medical Association Declaration of Geneva:

"I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity."

This statement was a reaction to the violation of the Hippocratic Oath by those medical personnel complicit in the crimes against humanity endorsed by the Third Reich.

Since the advent of legalized abortion, many medical schools have abandoned the Hippocratic Oath. As a result, few graduating medical students now take this life-affirming promise. However, the tide may be turning.

In 1996, a group of well-credentialed physicians developed a Restatement of the Hippocratic Oath* which has been widely accepted by doctors around the globe. A number of graduating medical students have gathered in small groups to swear this Oath in the presence of their families, peers, and mentors. A movement has begun to restore the medical profession to its moral and ethical moorings dating back 2,400 years.

* Available online at www.ncbcenter.org/oath.html

CHRONOLOGY OF THE ADVANCE OF IMPOSED DEATH IN AMERICA

In 1938, the Euthanasia Society of America (ESA) was founded in New York. In 1939, ESA proposed legislation for "voluntary" euthanasia. According to attorney Charles Nixdorff, ESA's treasurer, "the society hoped eventually to legalize the putting to death of non-volunteers beyond the help of medical science." ESA's president, Dr. Foster Kennedy, a neurologist, speaking before the Society of Medical Jurisprudence at the Academy of Medicine, urged legalizing euthanasia "primarily in cases of born defectives who are doomed to remain defective." These statements reveal the ultimate aim of the so-called "right to die" movement: the legalization of the "right to kill" persons who are deemed "defective" with or without their consent.

After numerous unsuccessful attempts to legalize euthanasia, ESA leaders realized that they must first change the mindset of the nation.

GLOSSARY

- **ESA:** Euthanasia Society of America
Subsequent names of this organization are: **SRD:** Society for the Right to Die, **Choice In Dying**, **PFC:** Partnership For Caring
- **EEC:** Euthanasia Education Council (an arm of ESA), later became **Concern for Dying**, then **Choice In Dying**
- **AAHS:** Americans Against Human Suffering
- **CID:** Compassion In Dying

ABBREVIATED TERMS

- **LW:** Living Will
- **PVS:** Persistent Vegetative State
- **PAS:** Physician-Assisted Suicide
- **DWD:** Death with Dignity

1967

- ESA launches a massive educational campaign, establishing the Euthanasia Education Council (EEC) and introducing the Living Will (LW) as a tool to promote discussion of euthanasia.

1973

- The first state LW-type legislation fails in Florida thanks to strong opposition from advocates for retarded children and the FL Catholic Conference. Rep. Walter S. Sackett, MD, introduced the bill as a cost-saving measure that would save billions of dollars "if the state's mongoloids were permitted to succumb to pneumonia."

1975

- ESA becomes the Society for the Right to Die (SRD), expunging "euthanasia" (a reminder of the Nazi killing program) from its name.

1976

- SRD experiences its first success: the California "Natural Death Act," a LW law, passes.
- Basing its decision on the "right to privacy," a NJ court permits a ventilator to be removed from 21-year-old Karen Ann Quinlan, diagnosed to be in a persistent vegetative state (PVS). She unexpectedly lives for nine more years, requiring only ordinary care, including tube-feeding.

1980

- British journalist, Derek Humphry, immigrates to the U.S. He and his second wife, Ann Wickett, start the Hemlock Society in CA. (In 1975, Humphry had helped his first wife kill herself and later wrote *Jean's Way*, a book recounting her "suicide.") Hemlock's purpose: to promote death-on-demand without any restrictions.

1984

- 22 states have adopted LW legislation and the push is on.

1986

- At a conference titled "A New Ethic for the New Medicine," the American Medical Association's Council on Ethical and Judicial Affairs issues this policy: "Even if death is not imminent, but a patient's coma is beyond doubt irreversible, ...it is not unethical to discontinue all means of life-prolonging medical treatment [including] medication and artificially or technologically supplied respiration, *nutrition and hydration* [emphasis added]. The Paul Brophy case is pending (see

"When Food and Water...", p. 11).

- Hemlock forms Americans Against Human Suffering (AAHS) to seek legalization of "physician-aid-in-dying" (medical homicide).

1987

- 32-year-old Nancy Ellen Jobes dies from dehydration at her parents' request. Even though two neurologists agreed that she was aware, responsive and purposeful, the NJ Supreme Court upheld lower court decisions that family members may refuse medical care even without clear evidence of a patient's wishes. SRD participated in this and all early "right to die" court cases.
- In his book *Setting Limits*, Daniel Callahan, director of the Hastings Center (a bioethical think tank), proposes rationing medical treatment after a certain (unspecified) age. This is consistent with previous statements, such as, "Given the increasingly large pool of super-annuated, chronically ill, physically marginalized elderly, [denial of food and water] could well become the non-treatment of choice..."³

1988

- AAHS fails to gather enough signatures to place its "physician-aid-in-dying" initiative on the CA ballot. Humphry calls the effort "a valuable dress rehearsal."
- The American Association of Retired Persons (AARP), which has lobbied for "right to die" legislation, is congratulated by the Hemlock Society of IL for printing an article promoting Hemlock, SRD, and Concern for Dying (formerly EEC).⁴

1989

- Hemlock Society headquarters move to Oregon, with plans to eventually place a "physician-assisted suicide" (PAS) initiative on the OR ballot.
- Medical journals increasingly give favorable treatment to assisted suicide and euthanasia, setting the stage for acceptance by doctors of physician-induced death.

1990

- In Michigan, Jack Kevorkian, an unemployed pathologist, hooks Janet Adkins to his "self-execution machine." His first known victim, Adkins, a 54-year-old Oregon woman, is in an early stage of Alzheimer's disease. Criminal charges against Kevorkian are dropped, but a judge orders him not



to use the machine again. Thumbing his nose at the legal system, he goes on a killing spree.

- The U.S. Supreme Court, in its only termination of food and fluids case to date, *Cruzan v. Missouri Department of Health*, upholds Missouri's requirement that there be "clear and convincing evidence" of an incompetent patient's wishes. Nevertheless, 33-year-old Nancy Cruzan is starved and dehydrated to death after a lower court finds new evidence — a casual conversation she allegedly had 12 years prior — to be "clear and convincing."
- The "Patient Self-Determination Act" (federal LW) is enacted (see "The

ERICA: Changing Medical Homicide into "Medical Treatment"

Money Factor," p. 6).

1991

- Derek Humphry's *Final Exit*, a suicide manual, hits the *NY Times* best seller list. (This book has been found next to the bodies of depressed suicide victims.)
- Washington voters reject the "Death With Dignity" — assisted suicide — initiative placed on the ballot by the Hemlock Society's WA State Chapter, led by Ralph Mero, a Unitarian minister.
- Choice in Dying forms by re-merging SRD and Concern for Dying (which split from SRD in 1979). Its main focus is promoting "end-of-life choices" through education and distribution of LW documents.



1992

- AAHS tries again in CA, collecting enough signatures to put a PAS initiative on the ballot. CA voters reject it.

1993

- Compassion in Dying (CID), a spin-off of the Hemlock Society, is founded in WA State to counsel the terminally ill and help them "with personal assistance, if necessary, to intentionally hasten death." Ralph Mero is its first executive director and president.

1994

- The Oregon "Death With Dignity

(DWD) Act" is narrowly approved by voters. Legal challenges ensue, blocking this PAS measure from taking effect.

- Every state now has some type of advance directive (LW or Durable Power of Attorney for Health Care) law.

1996

- After Jack Kevorkian assists the suicides of two women with non-terminal disabilities and is acquitted, disability activists form NOT DEAD YET. NDY makes news by picketing Kevorkian's home and conducting a sit-in at the Hemlock Society's Denver office. Disability rights groups' energetic opposition to assisted suicide becomes a "thorn in the side" for assisted suicide advocates.
- Barbara Coombs Lee replaces Mero at the helm of CID. She had helped draft, promote, and defend the OR "DWD Act." Under her leadership, CID becomes a well-funded national organization.

1997

- President Clinton signs the "Assisted Suicide Funding Restriction Act" prohibiting federal funds from paying for or promoting assisted suicide.
- The U.S. Supreme Court unanimously upholds the right of states to prohibit assisted suicide. This decision overturns rulings by the 9th Circuit Court of Appeals that WA State's law prohibiting assisted suicide is unconstitutional and by the 2nd Circuit Court that New York has no rational interest in preventing assisted suicide for the terminally ill. Both of these court challenges had been initiated by CID.
- A court clears the way for the OR "DWD Act" to go into effect; physicians may now write prescriptions for suicide. Oregonians vote down a bill to repeal the law.

1998

- Michigan voters crush PAS measure 71%-29%. In the ensuing years, the "right to die" movement meets with

failure after failure in state after state.

1999

- After assisting the deaths of at least 130 people, Kevorkian is convicted on one count of second degree murder. He had videotaped himself injecting lethal drugs into Thomas Youk, a man with Lou Gehrig's disease. CBS "60 Minutes" aired the video in 1998. It was used as evidence against Kevorkian. He is serving 10-25 years in prison.

2000

- 62-year-old Choice in Dying (originally ESA, then SRD) lays the groundwork for Partnership for Caring: America's Voices for the Dying (PFC), votes to dissolve itself, and transfers its programs and staff to PFC.

2001

- In Nov., U.S. Attorney General John Ashcroft announces that the Controlled Substances Act prohibits the use of federally controlled drugs for assisted suicide in Oregon because it is not a legitimate medical practice.

2002

- Oregon and assisted suicide supporters sue. U.S. District Judge Robert E. Jones rules against Ashcroft. Justice Department attorneys appeal Jones' ruling to a panel of three judges from the 9th U.S. Circuit Court of Appeals.

2003

- In Jan., the Hemlock Society holds its 13th Biennial Conference in San Diego at which the "Patients' Comfort and Control Act" (PCCA) is unveiled. This model bill allows a physician to prescribe a lethal overdose under the guise of the patient's control of medication. Hemlock officials claim it "will be very difficult for the federal government to block."
- Midsummer, Hemlock changes its name to "End of Life Choices."
- In a dramatic turn of events, on

10/21, the FL legislature enacts "Terri's law." This allows Gov. Jeb Bush to order Terri Schiavo's feeding tube reinserted after six days without food or water (see "The Case of Terri Schiavo," p. 12).

2004

- In Jan., the PCCA is introduced in AZ by Rep. Linda Lopez. She had previously introduced bills modeled on Oregon's assisted suicide law.
- On 3/20, Pope John Paul II definitively states that providing patients in "vegetative" states* with tube-administered food and fluids is "morally obligatory," and that no judgment on their quality of life could justify "euthanasia by omission."⁵ Unfortunately, most Catholic health facilities have ethicists who favor withdrawal of tube-feeding from PVS patients. Hopefully, they will now change their minds, but the Pope's statement is decisive, whether or not Catholic hospitals and ethicists choose to heed it.
- On 5/26, the 9th Circuit Court rules 2-1 that the U.S. Attorney General cannot penalize Oregon physicians who assist suicides by prescribing deadly doses of controlled substances (see 2001, 2002).

For more information:

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- *Smith, Wesley J., Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder, Spence Publishing, 2003.*

**The Pope objected to the term "vegetative" because, regardless of their infirmities, patients are and always will be human beings and "will never become 'vegetables' or 'animals.'"*

¹ *New York Times*, 1/27/1939:21

² *New York Times*, 2/14/1939

³ *The Hastings Center Report*, 10/83:22.

⁴ *Modern Maturity*, June-July, 1988.

⁵ *Address of John Paul II to the Participants in the International Congress on "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas*, 3/20/04.

"The debate over assisted suicide will continue to be waged at the ballot box, in legislatures, in courts of law and in the court of public opinion. Its importance merits not only meticulous examination, but also the commitment and dedication of those who seek to protect individuals, families and society."

Rita L. Marker, attorney and executive director of the International Task Force on Euthanasia and Assisted Suicide.

by Paul A. Byrne, MD (Professor of Pediatrics at Medical College of Ohio, Past President of the Catholic Medical Association)

If "brain death" and death were identical and equivalent, there would not be a need for the term "brain death."

Everyone knows that the body, the remains that are viewed at a funeral home, is dead. Compare that body to the patient in an intensive care unit who has been declared "brain dead" but who is receiving ventilatory support. The heart is beating, the blood pressure and temperature are being recorded, the color is normal, if the knee is tapped the knee jumps, and many internal organs and systems are functioning.

In the past, the physician took the time needed to determine death because he did not wish to treat the living as dead. Today, however, death is often declared for reasons not related to the patient's welfare — such as organ transplantation, cost containment and propagation of the euthanasia movement.

How did this change occur? Before 1968 the term "brain death" did not exist. A physician pronounced death when there was no breathing, no heart beat and no response to stimulation.

The removal of a beating heart for transplantation would have constituted murder under traditional standards for determining death.

Then, the *Journal of the American Medical Association* (JAMA) published an article entitled "A Definition of Irreversible Coma" (Vol. 205:337-340, 1968). This article included the Harvard Criteria which claimed irreversible coma represented "brain death." The newly coined "brain death" conveniently allowed the "harvesting" of vital organs for transplantation.

By 1978 there were more than 30 different sets of criteria for determining "brain death" published in the medical literature. Every set since the Harvard Criteria is less strict. For instance, the Harvard Criteria required that the patient be in a coma at least 24 hours. Other sets of criteria shortened the time to 12 hours, then six hours. More recently, in the *Cleveland Clinic Quarterly*, it was suggested that, after fulfilling certain clinical caveats, the patient can be taken off the ventilator

for 30 to 60 seconds and, if there is no breathing, the patient may be pronounced "dead." Other sets of criteria do not even require an electroencephalogram (EEG, a recording of electrical activity from the surface of the brain) — an omission that could result in a patient with cortical activity (memory, feelings, emotion, etc.) being declared "dead."

A physician is free to use any set of criteria. Thus, a patient could be determined to be dead by one set, but not by another.

Ironically, a patient who is determined to be "dead" (i.e. for transplantation or experimental purposes) is sometimes treated as if alive. Suction and postural drainage is done to prevent pneumonia. The patient is turned to prevent bed sores. How can a cadaver develop pneumonia or a bed sore?

The editor of JAMA, in the 9/3/82 issue, wrote:

"...[W]e are told a brain dead patient can nurture a child in the womb, which permits live birth sev-

eral weeks 'postmortem.' Perhaps this is the last straw that breaks the conceptual camel's back...the death of the brain seems not to serve as a boundary; it is a tragic, ultimately fatal loss, but not death itself."

Today, even though the medical community is divided about whether "brain death" is synonymous with death, every state has a "brain death" law.

Nevertheless, as Dr. Stuart Youngner wrote in a letter to the editor of the *New England Journal of Medicine*, 11/17/94, "The signs of life in brain dead patients...are very real and cannot be discounted in human terms, even if we have done so in public policy."

For more information:

- Bishop Fabian Wendelin Bruskewitz, Bishop Robert F. Vasa, Walt F. Weaver, Paul A. Byrne, Richard G. Nilges, and Joseph Seifert: "Are Organ Transplants Ever Morally Licit?" *The Catholic World Report*, 3/01:50-56.

NON-HEART-BEATING ORGAN DONATION

While questions about "brain death" are still being debated, it is now apparent that there are just not enough "brain dead" organ donors to satisfy the demand. The United Network for Organ Sharing, the organ procurement agency established by Congress in 1984, reports that an average of 17 people die each day following a futile wait for organs. The waiting list for transplants has 82,000 names.¹ One response to this organ supply crisis is to "redefine donor eligibility."

If you don't know what that means, join the crowd. There is a lot that some powerful people don't want the general public to know or ponder because consent rates are tied directly to perception. Patients and families who think donation is going to kill the patient refuse more often than those who believe the patient is already dead before organs are removed.

To "redefine donor eligibility," in laymen's language, simply means to allow organs to be taken from another group of people who are not dead yet.

Nancy Valko, RN, an intensive care

nurse and president of Missouri Nurses for Life, has sounded the alarm about the latest source of organs: non-heart-beating donors (NHBD). She explains:

The potential NHBD patient is alive but termed "hopeless" or "vegetative" by a doctor, usually soon after suffering a devastating condition like a severe stroke or trauma and while still needing a ventilator to breathe. Because of the legal acceptance of the so-called "right to die," families or patients can agree to have the ventilator turned off, a "do not resuscitate" order written, and the organs harvested if or when the person's breathing and heart-beat stops.

The patient is usually taken to an operating room where the ventilator is turned off. A doctor then watches for up to an hour until the heartbeat and breathing stop. In order to ensure healthy organs, speed is of the essence. Cardiac death is declared, the organ retrieval team waits two to five minutes (sometimes there is no waiting period), and then organ removal begins. The donor may be given an anesthetic before the surgeon begins to

cut, just in case the team acted too quickly.

"Just as disturbing," says Valko, "sometimes the patient will unexpectedly continue to breathe for longer than the one hour time limit for NHBD. The transplant is then cancelled but, rather than resuming care, the patient often is returned to his or her room to eventually die without treatment."

There is a saying that "doctors may be frequently in error, but never in doubt." For those who are aware of numerous recoveries after firm diagnoses of "hopeless" or "irreversible" the joke is not so funny. The rush to declare patients "hopeless," remove them from ventilators and take their organs will certainly deprive at least some of the chance to survive — or even recover.

Redefining donor eligibility is another push down the slippery slope of imposed death. NHBD protocols do not require that donors be mentally impaired. Merely exercising one's "right to die" may suffice. Disability advocate Diane Coleman has predicted:

There is going to be growing pressure on disabled people who are dependent on life support to "pull the plug." Allowing them to believe that they are being altruistic by doing so through organ donation will only increase the pressure on disabled people to choose to die in the belief that, by giving up their organs, their lives can have some meaning. The danger is especially acute for people who are newly disabled, many of whom believe, falsely, that their lives can never be worth living.²

Nationally, organ donation experts predict, NHBD could increase the number of eligible donors by about 14 percent.³ However, procuring an organ to save another's life can never morally or ethically justify killing the donor.

¹ "Transplant demand outpaces supply of brain-dead donors," *St. Louis Dispatch, AP*, 8/14/03

² Smith, Wesley J., *Culture of Death - The Assault on Medical Ethics in America*, Encounter Books, 2000.

³ Sherry, Allison, "Policy change could ease organ shortage: New studies spur hospitals' decision," *Denver Post*, 8/15/02.

Nutrition (food) and hydration (water) are basic human needs. It does not matter whether a person can feed himself, is spoon-fed by others or receives his meals through a feeding tube, the result of withholding food and fluids is universally the same: death.

If a person is unable to swallow, a tube is often used to deliver nourishment. A nasogastric (NG) tube is inserted through the nose and passed down the esophagus into the stomach. If tube feeding is needed over a long period, a gastrostomy (G) tube is surgically inserted through the abdomen directly into the stomach. After the initial surgery, there is rarely discomfort. The nourishment provided through feeding tubes is real food and water, not "artificial nutrition and hydration" as it is often misleadingly called. Tube feeding may be administered by any trained person, including the patient himself or family members. The cost is minimal.

It is important to distinguish different circumstances in which tube-feeding is withheld:

- When a person's body is shutting down during the natural dying process, or when the person is unable to receive food and water without harm, withholding tube-feeding is medically appropriate. In these cases, patients die from their disease or injury, not from dehydration. We are not addressing such situations here.
- When a person is not dying (or not dying quickly enough), food and fluids are often withheld because the person is viewed as having an unacceptably low quality of life and/or as imposing burdens on others. In these cases, patients are deliberately killed by dehydration and starvation.

Consider the cases of two elderly women. In 1984, 92-year-old Mary Hier had lived in a state hospital for more than fifty-seven years. Demented, but happy, she thought she was the Queen of England. Mary was not terminally ill, but had needed a feeding tube for many years. When her G-tube became dislodged, a court denied permission to replace it, declaring that it would be "a major medical procedure" with a "rela-

tively high risk" due to her age. Just as Mary's case was being reported, the same newspaper carried another story about a 94-year-old woman who was doing well after "minor surgery to correct a nutritional problem." The surgery, performed under local anesthesia on an outpatient basis, was the insertion of a G-tube. The woman was Rose Kennedy, matriarch of the rich and powerful Kennedy clan. Mary's life would have been prematurely ended without last minute intervention by a local physician and an attorney who exposed the inequity. Mary's tube was replaced. Both women lived for many more years.

In many instances, whether inserting a feeding tube is considered a "major" or "minor" procedure depends upon whether the person is viewed as expendable or valuable.

In the last 20 years, numerous court decisions and Living Will-type laws have authorized the dehydration and starvation to death of otherwise non-dying patients. Dr William Burke, a St. Louis neurologist, describes such a death:

*A conscious person would feel it [dehydration] just as you or I would. They will go into seizures. Their skin cracks, their tongue cracks, their lips crack. They may have nosebleeds because of the drying of the mucus membranes, and heaving and vomiting might ensue because of the drying out of the stomach lining. They feel the pangs of hunger and thirst. Imagine going one day without a glass of water! Death by dehydration takes 10 to 14 days. It is an extremely agonizing death.**

In 1984, at the 5th biennial conference of the World Federation of Right to Die Societies, Australian bioethicist Dr. Helga Kuhse explained the strategy of euthanasia advocates:

If we can get people to accept the removal of all treatment and care, especially the removal of food and fluids, they will see what a painful way this is to die, and then, in the patient's best interest, they will accept the lethal injection.

Patients who are permanently brain-damaged, but not dying, are frequently

victims of this strategy. Because they are unable to communicate, we cannot know precisely what they experience as they die of dehydration [see "Persistent Vegetative State," p. 14].

In 1983, Paul Brophy, a firefighter, lapsed into a coma after surgery for a ruptured brain aneurysm. On 10/3/86, Mr. Brophy died — eight days after medical personnel stopped his G-tube feedings with approval from the Supreme Court of Massachusetts. The court ruled that the G-tube could be removed or clamped, yet neither was done. When he began to have seizures, anticonvulsant medication was administered via the tube, as were antacids to prevent hemorrhaging and laxatives to make him more "comfortable" as he died.

Apparently, the feeding tube itself was not considered burdensome, for it was left in place. It was Mr. Brophy's life that was considered a burden.

In 1990, the United States Supreme Court ruled on its first "right to die" case, *Cruzan v. Director, Missouri Department of Health*. Nancy Cruzan was severely brain-damaged as a result of a car accident in 1983. She could hear, see, smile, cry and feel pain. Her parents went to court to force hospital employees to withdraw her food and fluids. The case made its way to our highest court, which upheld Missouri's law requiring "clear and convincing evidence" of a patient's wishes. A state court later heard new evidence presented by former co-workers who had known Ms. Cruzan briefly. They testified about a casual conversation that had taken place at work 12 years earlier. They could not recall whether Ms. Cruzan herself had stated that she would not want to live if she were profoundly disabled or whether she was in agreement with what others said. Considered "clear and convincing" by the lower court, that vague testimony sealed her fate. On 12/26/90, Nancy Cruzan died of dehydration after 12 days without food and fluids. She was 33 years old.

Beware! Offhand remarks such as "I'd rather die than live like that" may be set in proverbial stone.

Appearing life-protective at first, the Supreme Court's decision actually approved killing the disabled by dehydration and starvation. Its ruling merely meant that state laws could — but need not — regulate the practice by requiring clear and convincing evidence of a

patient's wishes to forgo life-sustaining treatment, including tube-feeding.

The plain truth is that food and fluids do not become "treatment" simply because they are taken by tube anymore than penicillin or Pepto-Bismol becomes "food" when taken by mouth.

Some proponents of imposed death, such as Dr. Kuhse, speciously frame the debate in terms of choosing the lesser of two evils: dehydration or lethal injection. (In essence, death or death. Some choice!) In fact, the issue is whether we will choose the evil of killing or the good of caring for the most vulnerable members of our human family.

* Smith, Wesley J., "Dehydration Nation," *The Human Life Review*, Fall 2003, Vol. XXIX, No. 4, pp. 69-79.

A Whale of a Tale!

An Oakland County, Michigan court sentenced a man to up to four years in jail for killing a cat by grabbing its legs and banging it over a porch railing. Oakland County is the home of Jack Kevorkian who killed 130+ vulnerable people before being convicted in one case in 1999. When a 4,200-pound whale beached itself near Clearwater, Florida, it was trucked to Sea World where it was fed and hydrated by a feeding tube. At the same time, American courts have ordered the removal of tube-feeding from vulnerable human beings such as Terri Schiavo, and dehydration has become a common way of death in many hospitals and nursing homes.

It is a tragic irony that, in pre-World War II Germany (1933), strong animal protection laws were passed. Fifteen years later, at the Nuremberg Tribunal which declared the Nazi euthanasia program a "crime against humanity," U.S. Brigadier General Taylor, chief counsel, concluded, "If the principles announced in this law had been followed for human beings as well, this indictment would never have been filed. It is perhaps the deepest shame of the defendants that it probably never occurred to them that human beings should be treated with at least equal humanity."

Who will sit in judgment on the United States?

Source regarding Nuremberg Tribunal: Gallagher, H.G., *By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich*, Henry Holt & Co., 1990.

Nat Hentoff, journalist for the Village Voice, has covered "right to die" cases for more than 25 years. It is noteworthy that he calls the reporting on the battle for Terri Schiavo's life "the worst case of journalistic malpractice I've seen."¹

One thing the media has largely missed is that Terri is disabled, not terminally ill, and that this case is first about disability rights, which affect millions of Americans. What makes Terri's case stand out is the public outcry in support of her right to live. More than 100,000 people contacted Florida Governor Jeb Bush, pressing him to save Terri's life. The various media have generally portrayed this outcry as coming from religious conservatives and "right to life" forces, and, indeed, they do deserve credit. However, as Hentoff observed, there has been "hardly any mention in the press of the deeply concerned voices of the disabled, many of whom, in their own lives, have survived being terminated by bioethicists and physicians who strongly believe that certain lives are not worth living."²

The real heroes are Terri's parents, Robert and Mary Schindler, who have been unrelenting in their campaign to save their daughter from death by dehydration.

Thanks to their persistence, not only is Terri still alive, but millions of people have been alerted to the fact that our judicial system has a deplorable history of sanctioning the treatment of disabled human beings in a way that would be criminal if done to a dog.

Terri's Condition

Now 40 years old, Terri has been permanently brain damaged since February 25, 1990, the day she collapsed and the oxygen supply to her brain was cut off for a period of time. Contrary to most media reports, Terri is not brain-dead, not comatose and not on a ventilator. Fourteen independent medical professionals have given either statements or testimony that Terri is not in a persistent vegetative state (PVS) and, given therapy, could improve. She could also learn to eat "normally." In 2002, internationally recognized neurologist William H. Hammesfahr, MD evaluated Terri. In a signed medical report he listed among his findings that she is responsive to her environment, responding to specific people best; tries to please others by doing activities for

which she gets verbal praise; attempts to verbalize; can swallow; and can feel pain.³

Court Battles

Almost three years after Terri's collapse, a medical malpractice jury awarded Terri \$700,000 for her ongoing medical care and \$300,000 to Terri's husband Michael Schiavo for loss of companionship. Shortly thereafter, Michael, who is also Terri's legal guardian, decided it was time for her to die. He denied her antibiotics for infection and all forms of rehabilitation. When she did not die, he sought to have her feeding tube removed. Terri's parents vehemently objected and asked to be named Terri's guardians.

The case ended up in Pinellas County Court, Judge George Greer presiding. Greer appointed an independent

Each appeal filed by attorney Patricia Anderson⁴ on behalf of the Schindlers in their determination to save their daughter's life has been met with Michael's resolve to end her life. At issue then and now is whether Terri is PVS. Under Florida law, she cannot be starved to death if she is not.

On October 17, 2001, the 2nd District Court of Appeals approved the Schindler's request to have Terri examined by independent doctors and ordered Judge Greer to hold an evidentiary hearing on the doctors' findings. Five medical experts were selected: two by Michael, two by the Schindlers, and one by Judge Greer. One of Michael's experts was Minnesota neurologist Ronald Cranford, who has testified in many "right" to die cases, without exception finding the patient to be PVS.

"Terri's law" declared unconstitutional. If a judge were to order the dehydration death of a condemned murderer, the ACLU would scream "cruel and unusual punishment!" Yet the ACLU claims such barbaric treatment respects Terri Schiavo's "right to die."

On November 23, 2003, Judge W. Douglas Baird, Pinellas Circuit Court, denied the Schindlers the right to join Governor Bush in defending "Terri's Law." On February 4, 2004, the 2nd District Court of Appeals rebuked Baird for failing to follow proper guidelines in dismissing Terri's parents' intervention request. In spite of this rebuke, on March 13 Baird once again prevented them from defending the law that was keeping their daughter alive. "Imagine being told that you have no interest in your own child," said Robert Schindler. "I cannot understand why this court

continues to deny our daughter protection but affords so much to her guardian."⁵

As for the \$700,000 awarded to Terri for her care and rehabilitation, it's almost gone. The courts have allowed Michael to use it to pay the attorneys he hired to fight to end Terri's life.

On May 6 Judge Baird declared "Terri's Law" unconstitutional. Governor Bush immediately filed an appeal and got an

automatic stay while Baird's ruling is reviewed by higher courts. It is likely that the constitutionality of the law eventually will be decided by the state Supreme Court.

Florida courts have thus far failed Terri Schiavo. Her life hangs by a thread. If Judge Baird or another court lifts the stay, Michael could cut that thread without waiting for the high court's decision.

For updates:

www.terrisfight.org

www.internationaltaskforce.org

¹ Hentoff, Nat, "A Woman's Life Versus an Inept Press," *Human Life Review*, Fall 2003, Vol. XXIX, No. 4:80

² Ibid.

³ Owen, Mary Jane, T.O.P., M.S.W., Executive Director, National Catholic Partnership on Disability, "Terri Schindler-Schiavo: A Stubborn Neurologically-Disabled Woman Who Refuses to Die," www.ncpd.org

⁴ Patricia Fields Anderson is an attorney in St. Petersburg who serves as American Center for Law and Justice (ACLU) local counsel representing the Schindlers.

⁵ www.lifenews.com, 3/13/04



Terri with her siblings, Terri now, and a favorite photo from the Schindler family as they remember Terri before the incident.

guardian at the request of Michael's own attorney, George Felos. That guardian, attorney Richard Pearse, reported to the judge that Michael was not a credible witness regarding his wife's wishes, pointing out that it was not until after the malpractice settlement that Michael stopped pursuing treatment for Terri. If his wife died, he would inherit her money and be free to marry the woman he'd been engaged to for four years and with whom he was living. Felos requested and obtained Pearse's removal.

In January 2000, Judge Greer conducted a hearing at which Michael argued that, before her collapse, Terri had told him that she would not want to be kept on life support. In spite of the fact that Terri had left no written evidence of her wishes and her parents insisted that she would not have made such a statement, Greer ruled that Michael could order all food and fluids withheld from Terri starting on March 12. The Schindlers appealed.

The two physicians chosen by Michael and his attorney George Felos (a euthanasia advocate) and the one appointed by Greer testified that Terri was PVS with no hope of improving. The physicians chosen by the Schindlers found that Terri was not PVS and could improve with treatment. Judge Greer ruled that Terri was PVS.

Terri's parents continued to plead for her life but, on October 15, 2003, with court permission, Michael had Terri's feeding tube removed. Finally, on October 21 the Florida legislature enacted an emergency measure, "Terri's law," which allowed the governor to order Terri's feeding tube reinserted. Michael's lawyers immediately threatened to sue any doctor who reinserted the feeding tube. Later that evening, Terri's feeding tube was reinserted and her recovery from six-and-a-half days of dehydration began.

Assisted by the American Civil Liberties Union, Michael sued to have

by Barbara A. Olevitch, Ph.D.

Editor's note: This commentary was written in anticipation of a hearing scheduled for September 11, 2003 in the Terri Schiavo case.

We will never forget the violent collapse of our World Trade Center and part of the Pentagon on September 11, 2001, and the families who received phone calls from their trapped loved ones who couldn't be saved.

We were stunned by the heartbroken families looking for their loved ones and also by the strangeness of the psychology of the hijackers. Americans read in disbelief how small changes in the fine print of non-mainstream Islamic interpretation were activated and spread to the point where a large pool of young men became available to commit mass murder.

How ironic that on September 11, 2003, a hearing is scheduled where Judge Greer, a Florida judge, is expected to allow the feeding tube to be removed from Terri Schiavo, after a five-year-long struggle in which her husband and guardian has tried to remove her feeding tube and her par-

ents have tried to save her life. How is the agony of Robert and Mary Schindler, her parents, to whom she responds with smiles, any different than the agony of the families who were helpless to prevent their still-alive loved ones from dying in the World Trade Center? They would also have to stand by, helpless to prevent death, and bewildered by the changes in our belief system that have allowed this to happen.

The right to refuse unwanted medical treatment has morphed gradually into a situation

where a husband has life and death power over his wife. Our clumsy laws designate her husband as next of kin, regardless of the troubled nature of this couple's relationship and the fact that he now lives with another woman and has a child by her, and regardless of the fact that Terri Schiavo has two parents who want to take care of her.

The right to refuse unwanted medical treatment has morphed gradually into a situation where a husband has life and death power over his wife.

Even more problematic than who should be the guardian is the institution of guardianship itself, dating from a time when medical choices were clear. It was the guardian's job to see that treatment was carried out. Now, since the right-to-die movement, the guardian's job has been distorted beyond recognition. In a free society,

how can we allow an American to be subservient to a guardian who can deny rehabilitation, deny visitors, deny a priest and deny nourishment?

Terri Schiavo, like any other adult in the United States, had the opportunity to write a living will or to name a health care surrogate, but she chose not to. That is the choice that we have to respect. She didn't make arrangements to be allowed to die or to deteriorate. To allow her guardian's interpretation of long-lost remarks that she made to have more legal significance than her

own choice is to put every American in the situation of those living in a dictatorship, who fear to speak lest their words be reported. In an America where anyone's memory of what you said during someone else's sickness could cause your own death at a later time, people will not be able to share feelings with one another.

If we cannot respect this woman's choice not to plan her death and to continue to enjoy her existence whether she improves or not, then we must ask ourselves whether we are beginning to resemble those who attacked us on September 11, 2001, because our ideas have also slipped and we are also killing innocent people.

Dr. Olevitch is a clinical psychologist and author of [Protecting Psychiatric Patients and Others from the Assisted-Suicide Movement: Insights and Strategies](#), Praeger, 1995.

Used by permission of the author.

A Proverb

There was an old woman living with her son, daughter-in-law and grandson. Grandma came to be what the family considered a "burden." She dropped dishes, spilled things and couldn't help with the farming. One day the couple had had enough and told their son to take the cart and his grandmother out to the woods — and leave her there in the cart. The boy dutifully escorted Grandma into the woods, but his parents were surprised when he returned with the cart. When they asked why, he responded, "If I left the cart, how could I take you to the woods when you become like Grandma?"

A Disability Perspective: Living by "Artificial" Means

by Mary Jane Owen, TOP, MSW

Hundreds of us are facing negative evaluations of the value of our lives every day. But in the case of Terri Schindler-Schiavo, the legal "right to kill" is expanded by court decisions in a way never anticipated a few short years ago. In October, the National Catholic Partnership on Disability joined a number of other national organizations to bring a disability perspective into the discussions of Terri's fight.*

"We come together for those who will be touched by disability in their lifetime and who will need our help to make their voices heard....Can she think? Hear? Communicate? These questions apply to thousands of people with disabilities who, like Ms. Schindler-Schiavo, cannot currently articulate their views and so must rely on others as substitute decision-makers....People with severe cognitive disabilities are devalued as lives not worth

living. In truth, the lives of all of us with severe disabilities are often considered expendable."

After citing a media report on how terrible it is to be kept alive artificially, we noted, "Meant to signal horror, the concept has no real meaning to us who live by 'artificial' means. Is a person on dialysis being kept alive artificially? Is a person taking insulin being kept alive artificially? Is a person who undergoes open-heart surgery, or cancer treatment, or intensive care in a hospital being kept alive artificially? It is a well-known fact among those of us who live with disabilities that a feeding

tube is a low-tech support, and people who use them can and do live full and meaningful lives. It was invented in the nineteenth century and relies on nothing more than gravity to make it work."

Each morning I get into my "artificial" mobility device: a wheelchair. I depend upon the "artificial" voice of my clock to tell me the time as I grab my "artificial" voice enhancement tool which I'll use to hear the noisy discussions of the day. After fixing breakfast and feeding my cat, I'll rush to get my ride to work, where I'll spend hours endeavoring to raise awareness of our Catholic bishops' call for accessible parishes and communities.



If those who think God must be out of His mind to place the precious gift of life into fragile bodies aren't educated to the gifts which accompany human vulnerability, I fear for our society and for our souls.

For more information:

• Downs, John F., "Why?", John Paul II Institute of Christian Spirituality, 2003. www.johnfdowns.com. Contact JPPI Institute at PO Box 7845, Jacksonville, FL 32238.

• www.notdeadyet.org.

* Read the full text of the "Joint Statement on Terri Schiavo's Right to Life" at www.ncpd.org, "Disability and Society."

Mary Jane Owen has been the executive director of the National Catholic Partnership on Disability since 1991. Contact NCPD at 202-529-2933, 420 Michigan Avenue, Suite 240, Washington, D.C. 20017.

The dehumanizing label "persistent vegetative state" (PVS) was crafted in 1972 just as the euthanasia movement began to take on steam. It became more familiar in the 1980s as neurologists began to use it as justification for withdrawing food and water from non-dying brain-injured patients.

Many people have blind faith in medical labeling. Most probably think that PVS is a simple diagnosis. However, experts disagree about what it is. Some medical dictionaries do not even include the phrase! While standards have been proposed, they are not accepted by the entire medical community, and methods for diagnostic testing are disputed.

A "vegetative state" is not a coma. According to the 1994 Multi-Society Task Force (MSTF) on the medical aspects of PVS, a person in a coma is neither awake nor aware; a person in a vegetative state is awake but not aware. The MSTF defined a persistent vegetative state as a vegetative state that lasts more than one month.¹

The person in PVS has sleep-wake cycles, eye movement, and normal respiratory, circulatory and digestive functions. Some have random movement, some do not; some can swallow, others cannot. Some have been physically injured, others suffer from stroke or dementia. In some cases the brain itself appears to change, in others it appears unchanged.

In simple terms, the diagnosis of PVS

is based on a lack of evidence of awareness of self or environment. However, it is not that simple.

Some patients who are diagnosed to be in PVS do exhibit evidence of awareness, but the diagnostician misses (or



dismisses) the evidence. They may be mute and immobile ("locked-in"), but mentally alert and able to communicate by blinking or through aids such as computers — if someone gives them the opportunity. Other patients retain some measure of awareness even though they do not exhibit any evidence of it. Patients who have recovered from such a state can recall things that were said or done to them while no one knew they were aware.

How reliable, then, is the diagnosis of PVS?

- In 2002, a study of mistaken diagnosis of PVS revealed a 15% error rate.²
- Data gathered by the MSTF on a group of 434 adult patients who were

treated as being vegetative."⁴

- A study of 84 patients with a "firm diagnosis" of PVS found that 41% regained consciousness by six months, 52% by one year, and 58% by three years.⁵

Studies show that PVS patients feel pain. Indeed, a University of Michigan neurologist, in one of the most complete studies, concluded that, when food and fluids are withdrawn [to impose death], the patient should be sedated.⁶

Some objections to imposed death for patients in PVS have rested on the hope that "they might recover." Let's face it: many people with severe disabilities will not recover. Killing them is not a cure — it is a "final solution," a crime against humanity.

Sadly, it is not uncommon for severely brain-injured patients to be warehoused in nursing homes, deprived of rehabilitation and other beneficial therapy. The unconscious world is far more complex than most of us can imagine. Those who have severe brain damage may still enjoy touch, scent, taste and sound; they may also feel loneliness, fear and despair.

Their inability to satisfy our longing for response does not justify abandonment or imposed death.

¹ Mappes, Thomas A., "Persistent Vegetative State, Prospective Thinking, and Advance Directives," *Kennedy Institute of Ethics Journal*, 2003:Vol. 13, No. 2: 119-139

² *Ibid*

³ *Ibid*

⁴ *British Medical Journal*, 7/6/96.

⁵ *British Medical Journal*, 8/92:304-305.

⁶ *Detroit Free Press*, 6/26/90:10A

in PVS as a result of traumatic injury showed that three months after injury, 33% of the patients had regained consciousness; by six months, 46% had; and at 12 months, 52% had.³

- Out of 40 patients diagnosed as being in PVS, 17 (43%) were later found to be alert, aware and often able to express a simple wish. The author, London neurologist Dr. Keith Andrews, said, "It is disturbing to think that some patients who were aware had for several years been

Misdiagnoses or Miracles?

A few (of many similar) cases to ponder:

- Carrie Coons, 86, was the first New Yorker for whom a "right to die" petition was approved by a court. She was diagnosed to be in an "irreversible" vegetative state. However, a judge withdrew permission to remove her feeding tube when she began talking and eating on her own. (*Newsweek*, 4/24/89)
- S.W. Winogron was saved by a wink of his eye just as a surgeon was preparing to remove his kidneys and eyes. (*Kansas City Times*, 2/3/75)
- Jackie Cole, 44, was diagnosed in a "permanent vegetative state." A judge ruled that life support could

be stopped. When a friend came to say goodbye, Jackie opened her eyes and smiled. She has been interviewed for television and print media numerous times. (*People*, 1/86)

- Arthur Wold, 30, had been labeled "severely mentally retarded" from age four. Unable to control his body, he could make only random gestures and say isolated words. But, in 1991, at a sheltered workshop, a counselor offered him a computer keyboard. He typed, "My name is Art." No one ever suspected he could read. When asked if he preferred to be called Arthur or Art, he spelled, "I don't care, just don't call me stupid." (*Parade Magazine*, 9/20/92)

- Kelly Barker, 35, was struck by a truck on September 1, 2003, suffering massive head injuries. She was diagnosed as being in a vegetative state with "irreversible damage" to her brain stem. Had food and water been stopped, this diagnosis would have been accepted as true, a self-fulfilling prophecy. In November, she started to show signs of alertness. While an aunt was visiting her during Thanksgiving weekend, Kelly suddenly sat up and slid her legs off the side of the bed. Now Kelly is giving kisses and hugs and, with assistance, taking long forceful strides up and down the halls of her nursing home. "I never expected her to make any meaningful neurological recovery," said Dr. Aaron

Ellenbogen, a neurologist with the Michigan Institute for Neurological Diseases, who has treated Kelly since her accident. The same doctors who pronounced her vegetative state to be irreversible call her recovery "miraculous" and "stunning." (*Detroit News*, 2/10/04)

Where there is life, there is hope. Patients deserve the time to recover and opportunities to develop and demonstrate their capabilities.

For more information:

- Brennan, William, PhD., *Dehumanizing the Vulnerable: When Word Games Take Lives*, Loyola University Press, 1995

by Tracy Berntsen (Contributing Writer, Human Life Alliance)

Dying is not only a matter of death, but a matter of life. The purpose of palliative care is to manage pain and other symptoms so that terminally ill patients may live life as fully as possible.

Hospice, which literally means "resting place," is the best known palliative care program. Hospice was founded in England in 1967 by Dame Cecily Saunders to provide for the physical, psychological, social and spiritual needs of terminally ill patients and their families while allowing death to occur naturally and in its own time. Hospice care is a team approach, with physicians, nurses, pharmacists, social workers, clergy and volunteers working with the patient and his or her family. Hospice care is available in many hospitals, nursing homes, free-standing hospice units and home-care programs.

Quality hospice care at the end of life has no equal. However, hospice has been undergoing some fundamental changes, practically and ethically.

Be Cautious

In the beginning, hospice operated as a charitable service rendered primarily by volunteers. Following the 1980s, when Medicare and Medicaid found it cost-effective to include such benefits, hospice became big business. The number of for-profit hospices and the number of Medicare recipients receiving hospice care more than doubled from 1992-1998. The most current data from the National Hospice and Palliative Care Organization report 3,200 hospice programs serving 875,000 dying Americans in 2002.¹ Unfortunately, as government and insurance (most HMOs currently provide hospice benefits) dollars rolled in, both fraud and cost-containment measures followed.

In 2000, Choice in Dying, comprised of right-to-die advocates, became part of a new organization, Partnership for Caring, founded by Dr. Ira Byock, a hospice physician.² Thus, the agenda of the right-to-die movement began to infiltrate the hospice industry.

The main criterion for eligibility for hospice care is a diagnosis of a "terminal illness" — a condition that is no longer curable with a life-expectancy of six months or less. Groups such as End of Life Choices (formerly The Hemlock Society) have sought to broaden the meaning of "terminal illness" to include a wide range of disabilities and old age infirmities. Stephen Drake, research analyst for Not Dead Yet, a national

disability rights group, recently addressed this development:

Among the legislative changes urged by "end of life" advocates has been the expansion of the definition of "terminal." Earlier this year, more than 45 disability groups sent a letter of protest to the Robert Wood Johnson Foundation,

with Crohn's Disease as "dying." The practical implication of this kind of advocacy is an increased acceptance in hospice to oversee the deaths of non-terminally ill people through denial of food, water, and basic medical treatment [emphasis added].³

Eliminate the Pain, Not the Patient

Proponents of "choice" in dying exploit and foster fear of pain in order to further their drive to legalize assisted suicide. But the reality is that no one should have to make the awful choice between intolerable pain and suicide. We are not awaiting some scientific breakthrough with which to conquer pain. There is already available a vast array of means to help patients live free of pain. Advances in pain management in recent years include new drugs, self-administered morphine pumps, epidural catheters, biofeedback and even clinics established specifically to treat pain.

In spite of the many benefits of good pain relief — such as patient well-being, medical cost savings, and less lost time from work — and in spite of the modern arsenal of weapons against pain, many patients live their last weeks and months in severe discomfort or pain. This can — and must — be changed!

One positive outcome of the discussion about assisted suicide is that doctors, nurses and the public are learning more about proper assessment and treatment of pain. Good pain management is a reality, but it requires dedication and time. Patients in pain and their families should insist that every effort be made to control pain, including consultation with a hospice physician/pharmacist or a referral to a pain management clinic if necessary. If a physician

does not have the knowledge, compassion or time necessary to assess and treat pain effectively, the patient should seek another doctor!

Researchers studying American cancer patients discovered that those who were actually in pain were more likely to reject the notion of assisted suicide and euthanasia than those who anticipate or fear pain. Researchers concluded that patients who are actually confronting the problem are more interested in getting rid of their pain than in dying. (*Lancet*, 6/29/96:1805-1810)

Sometimes, an unintended side effect of massive painkillers is to shorten life, e.g., large amounts of morphine may suppress respiration. But the intent is to alleviate pain and not to cause or hasten death. This is sometimes referred to as the principle of "double effect"; most ethicists agree that this is not euthanasia. Doctors know the difference between killing pain and killing a patient — and should be held accountable.

Assisted suicide may appear to be an attractive "quick fix" because it is easier and cheaper than care and treatment. People should worry about that.

For more information:

- Cheven, Eric M. and Smith, Wesley J., *Power Over Pain, International Task Force on Euthanasia and Assisted Suicide*, 2002.

Recommendations

Those seeking hospice care should be fully aware of patients' rights, the terms of the HMO, Medicare/Medicaid or other insurance covering the cost, and the policies and procedures of the program or agency being considered.

It is important to know that:

- Hospice insurance benefits can be revoked for any reason and at any

time by the patient or his legal representative.

- It is possible to transfer to another hospice. This is normally allowed once during each certification period of six months.
- There are provisions for extending hospice benefits beyond the initial six month period.⁴
- Treatments and medications for all conditions except a terminal illness are to be continued. Drugs and treatment must be provided for the palliation and management of the terminal disease and related conditions.
- There are patient advocates and advocacy groups that provide assistance to patients and families seeking quality hospice care.

It is also important to know the agency's policies concerning assisted feeding, prescription drugs, use of morphine and procedures for handling patients' requests concerning the termination of services, medications and/or treatments.

Be informed, but always keep in mind that palliative care is "care" — not cure — and that the emotional trauma surrounding death and the loss of a loved one sometimes finds its outlet in unreasonable expectations and the blaming of a system or an individual caregiver.

Home hospice care provides the ideal situation wherein the patient, supported by hospice professionals, remains at home. When home care is not feasible or advisable, the importance of a bedside advocate cannot be overstated. The dedicated, designated individual (appointed through a Power of Attorney for Health Care) who will make decisions when the patient is no longer able and is available to assist the patient, will assure the dying person of the charity and the particular charism intended by Dame Cecily Saunders.

For more information:

- Hospice Patients Alliance, Inc (616) 866-9127 www.hospicepatients.org

¹ American Medical News: <http://www.ama-assn.org/amednews/2004/01/26/prsa0126.htm>

² Dial, RN, Kathy, "Are Euthanasia Advocates Taking Over America's Hospice Industry?" *LifeNews.com*, 12/19/03.

³ Drake, Stephen, "End of Life Planning: Q & A with a disabilities advocate," *Special to the Reno Gazette-Journal*, 11/22/03.

⁴ Barbero, RN, Barbara, "Hospice Limitations," www.learningplaceonline.com/stages/together/hospice/hospice-limitations.html, 3/6/04.

Life is Worth Living!



12 Ways You Can Combat Imposed Death

- Listen and read critically. Reject the vocabulary of the euthanasia lobby. Become better informed so you can better inform others.
- Insist that laws protecting the medically vulnerable are enforced.
- Be a voice for the vulnerable. Watch for pro-death efforts in your state and speak out in defense of life through letters to the editor, etc. Encourage public officials and policy makers to protect those who are medically vulnerable.
- Reach out. A visit, phone call, or cheerful note to someone who is elderly, disabled, lonely, chronically ill or dying means a lot!
- Support and assist families and other caregivers. Caregivers often experience "compassion fatigue." Exhaustion makes it difficult to maintain a positive, hopeful and loving outlook.
- Be informed about patients' legal rights to: receive respectful care; access information; participate in medical decisions; and designate someone to speak for them.
- Demand that doctors be competent in pain management and that accrediting agencies carefully assess the care of patients in nursing homes and hospitals.
- Improve nursing homes; uncover and correct deficiencies and abuses.
- Join or start a pro-life group. Actively defend those who may be targeted for death.
- Volunteer at a day care or respite care program to allow family members to work or recreate while their loved one is cared for and stimulated.
- Encourage ethical and moral medical research that will improve lives.
- Choose a pro-life physician.

About Human Life Alliance

Human Life Alliance (HLA) is a non-profit, non-denominational, pro-life organization with a 501(c)3 tax-deductible status dedicated to protecting life from conception to natural death.

- HLA was founded in 1977 by pro-life volunteers dedicated to:
- Raising awareness of the humanity of the pre-born child and exposing the gruesome realities of abortion.
 - Opposing euthanasia in all its forms and fighting for protection of all human beings, including the elderly, disabled and medically vulnerable.
 - Promoting chastity and abstinence until marriage; educating on the errors and health risks of "safe-sex" promotion.

Mission Statement

Human Life Alliance celebrates the inherent dignity and personhood of human life, born and unborn, without exception or compromise. Human Life Alliance proclaims and defends a culture of life and chastity through education, social and political awareness and life-affirming alternatives to abortion, infanticide, assisted suicide and euthanasia. Human Life Alliance accomplishes its mission in a spirit of prayer and non-violence.

For More Information:

Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____

- ☐ I want to make a tax-deductible contribution to help HLA's pro-life efforts across the country!
- ☐ Please send me a copy of other HLA life-saving publications.
- ☐ Please send me a complimentary copy of *HLA Action News* (published quarterly).



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